CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services

If you have permanent kidney failure, this official government booklet explains

- ★ the basics of Medicare.
- ★ how Medicare helps pay for kidney dialysis and kidney transplants.
- ★ where to get help.

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Introduction

Learning that you have permanent kidney failure isn't easy. Even though you may feel sad, confused, or frustrated, you can still take control of your life. The fact that you're reading this booklet is a start.

Words in red are defined on pages 51–52.

This booklet explains how Medicare helps pay for kidney dialysis and kidney transplant services in the Original Medicare Plan. If you are in a Medicare Advantage Plan (like an HMO or PPO)*, your plan must give you at least the same coverage that the Original Medicare Plan gives, but it may have different rules. Your costs, rights, protections, and/or choices of where you get your care may be different if you are in a Medicare Advantage Plan, and you may be able to get extra benefits. Read your plan materials or call your benefits administrator for more information.

This booklet doesn't have detailed information about kidney failure, dialysis treatments, and kidney transplants. To learn more about these things, talk with your health care team. Your doctors, nurses, social workers, dieticians, and dialysis technicians make up your health care team. They are there to help you. You should also talk with your doctor about your treatment options. You and your doctor can decide what's best for you based on your situation.

Learning about Medicare can be confusing. If you have questions after reading this booklet, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also look on page 48 for information on how to get phone numbers of people who can help you. You can also talk to the social worker at your dialysis facility or transplant center to get help understanding what is and isn't covered by Medicare.

* In most cases, you can't join a Medicare Advantage Plan if you have End-Stage Renal Disease (see page 8).

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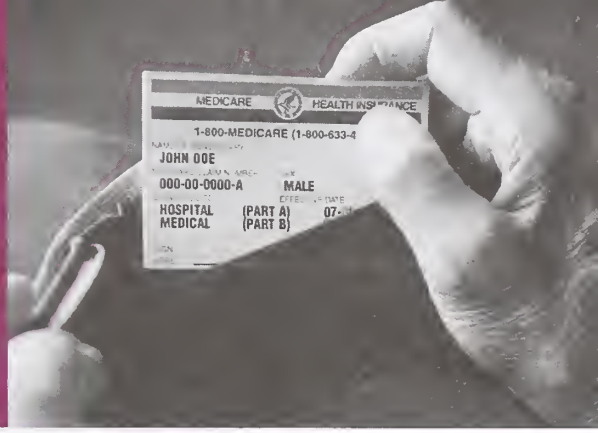
Medicare Basics



What is Medicare?

Medicare is a health insurance program for people

- age 65 and older,
- under age 65 with certain disabilities,
- any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant, sometimes called ESRD).

What Medicare Covers

Medicare Part A (hospital) helps cover

- inpatient care in hospitals
- inpatient care in skilled nursing facilities (not custodial or long-term care)
- hospice care
- some home health care

Medicare Part A Costs

Most people don't have to pay a monthly premium for Part A because they (or a spouse) paid Medicare taxes while they were working.

Medicare Part B (medical) helps cover

- doctors' services
- outpatient hospital care
- other medical services that Part A doesn't cover (like physical and occupational therapy)

Part B helps pay for these covered medical services and items when they are medically necessary.

To get more details about what Medicare covers, visit www.medicare.gov on the web. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What Medicare Covers (continued)

Medicare Part B Costs

Everyone must pay a monthly premium for Medicare Part B. The standard Medicare Part B premium for 2007 is $93.50 per month. Premium rates can change yearly. Any change in the Part B premium amount will be effective on January 1st of each year. This amount may be higher if you don't sign up for Part B when you first become eligible. Also, if you are single and your yearly income is more than $80,000, or if you are married and your combined yearly income is more than $160,000, your monthly premium will be higher. For more information about the Medicare Part B premium, call Social Security at 1-800-772-1213. TTY users should call 1-877-486-2048.

Paying for Medicare Part B

When you sign up for Medicare Part B, the premium is usually taken out of your monthly Social Security, Railroad Retirement, or Office of Personnel Management payment. If you don't get one of these payments, Medicare sends you a bill for your Part B premium every three months. You should get your Medicare premium bill by the 10th of the month. If you don't get your bill by the 10th, call Social Security at 1-800-772-1213.

Remember, you must pay your Medicare Part B premium. If you don't pay your Part B premium, or if you choose to cancel it, your Medicare Part B coverage will end. You need Medicare Part B to get the full benefits available under Medicare for people with ESRD.

Who is Eligible?

You can get Medicare Part A no matter how old you are if your kidneys no longer work and you need regular dialysis or have had a kidney transplant, and you

- have worked long enough under Social Security, the Railroad Retirement Board, or as a government employee; or
- are getting or are eligible for Social Security, Office of Personnel Management, or Railroad Retirement benefits; or
- are the spouse or dependent child of a person who has worked the required amount of time under Social Security, the Railroad Retirement Board, or as a government employee or who is getting Social Security, Federal retirement, or Railroad retirement benefits.

Who is Eligible? (continued)

If you get Medicare Part A, you can also get Medicare Part B. Enrolling in Part B is your choice. However, **you will need both Part A and Part B in order for Medicare to cover certain dialysis and kidney transplant services.**

If you don't qualify for Medicare, you may be able to get help from your state to pay for your dialysis treatments (see pages 43–44).

* Call Social Security at 1-800-772-1213 for more information about the required amount of time needed under Social Security, the Railroad Retirement Board, or as a government employee to be eligible for Medicare based on ESRD. Or, visit www.socialsecurity.gov on the web.

Medicare Plan Choices

Medicare offers different choices in how you get your health and prescription drug coverage. Your costs will vary depending on your coverage and the services you use.

Words in red are defined on pages 51–52.

If you have ESRD and you are new to Medicare, you will most likely get your health care through the Original Medicare Plan. The Original Medicare Plan is a fee-for-service plan managed by the Federal Government. You can go to any doctor or supplier that is enrolled and accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility. You pay a set amount for your health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance or copayment) for covered services and supplies.

When you are in the Original Medicare Plan, you can add prescription drug coverage, by joining a Medicare Prescription Drug Plan. Private companies approved by Medicare run these plans. Different plans cover different drugs, but most medically necessary drugs must be covered. See pages 35–38 for more information about Medicare Prescription Drug Plans.

You may also have the option of joining a Medicare Special Needs Plan if one is available in your area for people with ESRD. These plans aren't available in all areas and only a few serve people with ESRD. Medicare Special Needs Plans are a type of Medicare Advantage Plan. They are designed for people with certain chronic diseases and other specialized health needs. These plans must provide all Medicare Part A and Part B health care and services. They also must provide Medicare prescription drug coverage (Part D).

Medicare Plan Choices (continued)

Words in red are defined on pages 51–52.

If you've had a kidney transplant, you can join the Original Medicare Plan or you may be able to join a Medicare Advantage Plan (like an HMO or PPO) in limited situations.

If you are already in a Medicare Advantage Plan, you can stay in the plan you are in, or join another plan offered by the same company in the same state.

If your Medicare Advantage Plan leaves Medicare or no longer provides coverage in your area, you have a one-time right to join another Medicare Advantage Plan if one is available in your area. You don't have to use your one-time right to join a new plan immediately. If you change directly to the Original Medicare Plan after your plan leaves or stops providing coverage, you will still have a one-time right to join a Medicare Advantage Plan at a later date as long as the plan you choose is accepting new members.

For more information about your Medicare plan choices, look at a copy of the "Medicare & You" handbook. You can also call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web to get more information.

How to Sign Up for Medicare

If you need Medicare because of ESRD, you can enroll in Medicare Part A and Part B based on ESRD by visiting your local Social Security office or by calling Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

In order to avoid paying a higher Part B premium, you should enroll in Medicare Part B when you apply for Medicare Part A based on ESRD. The cost of Part B will go up 10% for each 12-month period that you could have had Part B but didn't sign up for it. If you have employer or union group health plan coverage, see pages 11–13.

If you are already paying a higher Part B premium because you didn't enroll in Part B when you were first eligible for Medicare based on age or disability, the premium will be reduced to the standard rate ($93.50 in 2007) when you become entitled to Medicare based on ESRD. Call your local Social Security office to make an appointment to enroll in Medicare based on ESRD.

Medicare Basics

When Medicare Coverage Begins

When you enroll in Medicare based on ESRD and you are on dialysis, your Medicare coverage usually starts the first day of the fourth month of dialysis treatments. For example, if you start getting your hemodialysis treatments in July, your Medicare coverage would start on October 1.

If you are covered by an employer or union group health plan, your Medicare coverage will still start the fourth month of dialysis treatments. Your employer or union group health plan will pay first on your health care bills and Medicare will pay second for a 30-month coordination period. For more detailed information, see pages 11–13, "How Medicare Works With Employer or Union Group Health Plan Coverage."

If you don't have employer group health plan coverage, there are other types of insurance and programs that may help to pay some of your health care costs (see pages 42–44).

There Are Three Ways You May Be Able to Get Medicare Coverage Sooner

1. **Medicare coverage can start as early as the first month of dialysis if you**
   - take part in a home dialysis training program in a Medicare-approved training facility to teach you how to give yourself dialysis treatments at home; and
   - begin home dialysis training before the fourth month of dialysis; and
   - expect to finish the training and give yourself dialysis treatments.
2. **Medicare coverage can begin the month you are admitted to a Medicare-approved hospital for a kidney transplant or for health care services that you need before your transplant if**
   - your transplant takes place in that same month or within the two following months.

Important: Medicare won't cover surgery or other services that are needed to prepare for dialysis (such as surgery for a blood access [fistula]) if done before Medicare coverage begins.

When Medicare Coverage Begins (continued)

There Are Three Ways You May Be Able to Get Medicare Coverage Sooner (continued)

3. **Medicare coverage can begin two months before the month of your transplant if**
   - your transplant is delayed more than two months after you are admitted to the hospital for the transplant or for health care services you need before your transplant.

> **Example**
> Mrs. Perkins was admitted to the hospital on May 25th for some tests she needed before her kidney transplant. She was supposed to get her transplant on June 15th. However, her transplant was delayed until September 17th. Therefore, Mrs. Perkins' Medicare coverage will start in July, two months **before** the month of her transplant.

When Medicare Coverage Ends

If you have Medicare only because of kidney failure, your Medicare coverage will end

- 12 months after the month you stop dialysis treatments, or
- 36 months after the month you have a kidney transplant.

Your Medicare coverage will be extended if

- you start dialysis again or you get a kidney transplant within 12 months after the month you stopped getting dialysis, or
- you start dialysis or get another kidney transplant within 36 months after the month you have a kidney transplant.

> **Important:** Remember, you need both Medicare Part A and Part B to get the full benefits available under Medicare for people with ESRD. If you don't pay your Medicare Part B premium or if you choose to cancel it, your Medicare Part B will end.

How Medicare Works With Employer or Union Group Health Plan Coverage

If you are eligible for Medicare only because of permanent kidney failure, your eligibility usually can't start until the fourth month of dialysis (see page 9). Therefore, if you have coverage under an employer or union group health plan, that plan will be the only payer for the first three months of dialysis (unless you have other sources of coverage as well).*

Words in red are defined on pages 51–52.

Once you become eligible for Medicare based on kidney failure (usually the fourth month of dialysis), if you enroll, there will still be a period of time when your employer or union group health plan will continue to pay your health care bills. However, if your plan doesn't pay 100% of your health care bills, Medicare may pay some of the remaining costs. (This is called "coordination of benefits," under which your plan "pays first," and Medicare "pays second.") This coordination period lasts for 30 months. During this 30-month coordination period, Medicare is called the secondary payer.

When the 30-Month Coordination Period Starts

Note: The 30-month coordination period starts the first month you would be able (eligible) to get Medicare because of kidney failure (usually the fourth month of dialysis), **even if you haven't signed up for Medicare yet**. For example, if you start dialysis in June, the 30-month coordination period will start September 1, the fourth month of dialysis.

If you take a course in self-dialysis training or get a kidney transplant during the three-month waiting period, the 30-month coordination period will start earlier (see pages 9–10). During this time, Medicare will be the secondary payer.

Important: If you have employer or union group health plan coverage, tell the doctor or other person who provides your medical care that you have this coverage. This is very important in order to make sure that your services are billed correctly.

* If your employer or union plan doesn't pay all costs for dialysis, you may have to pay some of the costs. You may be able to get help paying these costs (see pages 41–44).

How Medicare Works With Employer or Union Group Health Plan Coverage (continued)

What Happens When the 30-Month Coordination Period Ends?

At the end of the 30-month coordination period, Medicare will pay first for all Medicare-covered services. Your employer or union group health plan coverage may pay for services not covered by Medicare. Check with your plan's benefits administrator.

How the 30-Month Coordination Period Works if You Enroll in Medicare More Than Once

There is a separate 30-month coordination period each time you enroll in Medicare based on kidney failure. For example, if you get a kidney transplant that continues to work for 36 months, your Medicare coverage will end. If after 36 months you enroll in Medicare again because you start dialysis or get another transplant, your Medicare coverage will start right away. There will be no three-month waiting period before Medicare begins to pay. However, there will be a new 30-month coordination period if you have employer or union group health plan coverage.

Do I Have to Get Medicare Because My Kidneys Fail, if I Already Have an Employer or Union Group Health Plan?

No, but you should think carefully about this decision. If you already have an employer or union group health plan, consider the following:

1. If you get a kidney transplant, Medicare Part B will cover your immunosuppressive drugs (see pages 28–29) **only if** you have Medicare Part A at the time of the transplant and
   - the transplant is paid for by Medicare, or
   - Medicare doesn't pay for the transplant because Medicare is secondary payer to your employer or union group health plan, or
   - you are entitled to Medicare because of age or disability.

In each instance, the transplant surgery must have taken place in a Medicare-approved facility. In addition to the above conditions, you must have Medicare Part B coverage at the time you get the immunosuppressive drugs.

Words in red are defined on pages 51–52.

If you don't meet the conditions for Part B coverage of immunosuppressive drugs, you may be able to get coverage by enrolling in a Medicare Prescription Drug Plan, see pages 35–38.

How Medicare Works With Employer or Union Group Health Plan Coverage (continued)

Do I Have to Get Medicare Because My Kidneys Fail, if I Already Have an Employer or Union Group Health Plan? (continued)

2. If your group health plan coverage has a yearly deductible or coinsurance, enrolling in Medicare Part A and Part B could help pay those costs.
3. If your group health plan coverage will pay for most or all of your health care costs—for example if it doesn't have a yearly deductible, you may want to delay enrolling in Medicare Part A and Part B until the 30-month coordination period is over. If you delay enrollment, you won't have to pay the Part B premium for coverage you don't need yet. After the 30-month coordination period, you should enroll in Medicare Part A and Part B. Your Part B premium will be higher because you delayed your enrollment. If your group health plan benefits are decreased or end during this period, you should enroll in Medicare Part A and Part B as soon as possible.

Words in red are defined on pages 51–52.

For More Information About How Employer or Union Group Health Plan Coverage Works With Medicare

- get a copy of your plan's benefits booklet, or
- call your benefits administrator and ask how the plan pays when you have Medicare.

Medicare for Children With ESRD

Medicare coverage based on ESRD covers people of all ages including children. Medicare can help cover your child's medical costs if your child needs regular dialysis because his or her kidneys no longer work, or he or she has had a kidney transplant. You or your spouse must also have the required amount of credits under Social Security, the Railroad Board, or as a Federal Government employee.

Use the information in this booklet to help answer your questions. You can also contact your local Social Security office or call 1-800-772-1213. TTY users should call 1-800-325-0778.

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Kidney Dialysis

What is Dialysis?

Dialysis is a treatment that cleans your blood when your kidneys don't work. It gets rid of harmful wastes, and extra salt and fluids that build up in your body. It also helps control blood pressure and helps your body keep the right amount of fluids. Dialysis treatments help you feel better and live longer, but they are not a cure for permanent kidney failure.

Where to Get Dialysis Treatments

Dialysis can be done at home or in a medical facility. In order for Medicare to pay for your treatments, the facility must be approved to provide dialysis (even if they already provide other Medicare-covered health care services).

At the dialysis facility, a nurse or a trained technician may give you the treatment. At home, you can treat yourself with the help of a family member or friend. If you decide to do home dialysis, you and your helper will get special training. (See page 16, "Home Dialysis Treatment Options.")

Words in red are defined on pages 51–52.

If you have a problem with the care you're getting from your dialysis facility, you have the right to file a grievance (complaint) to resolve your problem. See page 40, "Filing a Grievance (Complaint)," for more information.

How to Find a Dialysis Facility

In most cases, the facility your kidney doctor works with is where you will get dialysis treatments. However, you have the right to choose to get your treatments from another facility at any time. Keep in mind, this could mean changing doctors.

You can also call your local ESRD Network (see pages 49–50) to find a facility that is close to you. Or, you may use "Dialysis Facility Compare" on the web (see the next page for more information).

How to Find a Dialysis Facility (continued)

"Dialysis Facility Compare" on the Web

"Dialysis Facility Compare" has important information about Medicare certified dialysis facilities in your area and around the country. Visit www.medicare.gov on the web. Under "Search Tools," select "Dialysis Facility Compare." You can find information such as addresses and phone numbers, how far certain facilities are from you, and what kind of dialysis services the facilities offer. You can also compare facilities by the services they offer and by certain quality of care information. Helpful websites, publications, and telephone numbers are also available. You can discuss the information on this website with your health care team.

If you don't have a computer, your local library or senior center may be able to help you look at this information. You can also call 1-800-MEDICARE (1-800-633-4227) or contact your local State Health Insurance Assistance Program (see pages 49–50), to get help with comparing dialysis facilities.

Home Dialysis Treatment Options

There are two types of dialysis that can be done at home:

1. **Hemodialysis** uses a special filter (called a dialyzer) to clean your blood. The filter connects to a machine. During treatment, your blood flows through tubes into the filter to clean out wastes and extra fluids. Then the newly cleaned blood flows through another set of tubes and back into your body.
2. **Peritoneal dialysis** uses a special solution, called dialysate, that flows through a tube into your abdomen. After a few hours, the dialysate has taken wastes from your blood and can be drained from your abdomen. After draining the used dialysate, your abdomen is filled with fresh dialysate and the cleaning process begins again.

How Do I Know What Type of Dialysis I Need?

You should work with your doctor and your health care team to decide the type of dialysis you need. You and your doctor can decide what's best for you based on your situation. The goal is to help you stay healthy and active.

Knowing How Well Your Dialysis is Working

With the right type and amount of dialysis, you will probably

- feel better and less tired.
- have a better appetite and less nausea.
- have fewer hospital stays and live longer.

You can tell how well the dialysis is working with blood tests that keep track of your URR or Kt/V (**pronounced kay tee over vee**) number. These numbers tell your doctor or nurse how well dialysis is removing wastes from your body. Your doctor or nurse usually keeps track of one or both of these numbers, depending on which test your dialysis facility uses.

A URR of 65 percent and a Kt/V of 1.2 are the **minimum** numbers for adequate dialysis. Your doctor or dialysis center may set a higher dialysis goal for your health and to make you feel better. This means a URR higher than 65 percent and a Kt/V higher than 1.2 are okay. Talk to your doctor about your number.

I feel fine. Why should I check how well my dialysis is working?

In the short run, some people may feel okay without adequate dialysis. In the long run, not getting enough dialysis can make you feel weak and tired. It can lead to a higher risk of infection and prolonged bleeding. It can shorten your life.

What steps can I take to have adequate dialysis?

- Go to all of your scheduled treatments and arrive on time.
- Stay for the full treatment time.
- Follow your diet and fluid restrictions.
- Follow the advice of your dialysis staff on taking care of yourself.
- Check your URR or Kt/V adequacy number every month.
- Talk to your doctor about which hemodialysis vascular access* is best for you.
- Learn how to take care of your access.

To learn more about how well your hemodialysis is working, talk with your doctor or other health team members at your dialysis facility.

* Your vascular access is the entrance your doctor makes into your blood vessels. During dialysis, your blood is removed and returned through your vascular access.

Dialysis Services and Supplies Covered by Medicare

Medicare covers these dialysis services and pays part of their costs:

Service or Supply	Medicare Part A	Medicare Part B
Inpatient dialysis treatments **(if you are admitted to a hospital for special care)**	✔	
Outpatient dialysis treatments **(when you get treatments in any Medicare-approved dialysis facility)**		✔
Self-dialysis training **(includes instruction for you and for the person helping you with your home dialysis treatments)**		✔
Home dialysis equipment and supplies **(like alcohol, wipes, sterile drapes, rubber gloves, and scissors)**		✔
Certain home support services **(may include visits by trained hospital or dialysis facility workers to check on your home dialysis, to help in emergencies when needed, and to check your dialysis equipment and water supply)**		✔
Certain drugs for home dialysis **(see page 19)**		✔
Outpatient doctors' services		✔
Most other services and supplies that are a part of dialysis, like laboratory tests		✔

To find out what you pay for these services, see pages 20–25.

Dialysis Services and Supplies Covered by Medicare (continued)

Home Dialysis Drugs Covered by Medicare

Words in red are defined on pages 51–52.

The most common drugs that Medicare Part B covers for home dialysis are

- heparin, which help to prevent blood clots
- an antidote to reverse the action of heparin if medically necessary
- topical anesthetics applied to your skin to relieve pain and itching
- Epogen or Epoetin alfa to treat anemia

Talk with your doctor or any member of your health care team about the use of these and any other drugs.

Dialysis Services and Supplies NOT Covered by Medicare

Medicare **doesn't** cover the following services or supplies:

Service or Supply	Not Covered
An aide to help you with home dialysis	×
Any lost pay to you and the person who may be helping you during self-dialysis training	×
A place to stay during your treatment	×
Blood or packed red blood cells for home self dialysis unless part of a doctors' service or needed to prime the dialysis equipment	×
Transportation to the dialysis facility (see page 26 for coverage in special cases)	×

There are some types of insurance that may pay some of the health care costs that Medicare doesn't pay (see pages 41–44). For more information on Medicare prescription drug coverage, see pages 35–38.

Kidney Dialysis

What YOU Pay for Dialysis Services

The costs listed in this section are for dialysis services in the Original Medicare Plan. If you are in a Medicare Advantage Plan or have a supplemental policy that pays the costs that Medicare doesn't, your costs may be different. Read your plan materials or call your benefits administrator to get information about your costs.

Dialysis in a Dialysis Facility

In the Original Medicare Plan, if you get dialysis in a Medicare-approved facility (independent or hospital-based), Medicare Part B pays the facility for dialysis-related services at a per treatment rate (called the composite rate). This rate may be different from one dialysis facility to another, depending on the type of facility and where it's located. Medicare pays 80% of the composite rate. You pay the remaining 20% coinsurance that Medicare doesn't pay.

Example
Let's say the composite rate is $150 per treatment. After you pay the $131 (in 2007) Part B yearly deductible,

- Medicare Part B pays the facility 80% of $150 (or $120), and
- you pay the remaining 20% coinsurance (or $30).

Words in red are defined on pages 51–52.

There may be other Medicare-covered services that aren't included in the composite rate like certain Part B covered drugs. Your dialysis facility can give you a list of tests and other services that are included in this rate. For services not included in the composite rate, Medicare pays 80% of the Medicare-approved amount. You must pay the 20% coinsurance.

Dialysis in a Hospital

If you are admitted to a hospital and get dialysis, your treatments will be covered by Medicare Part A as part of the costs of your covered inpatient hospital stay.

Kidney Dialysis

What YOU pay for Dialysis Services (continued)

Medicare covers these dialysis services and pays part of their costs:

Doctors' Services

Outpatient Doctors' Services

In the Original Medicare Plan, Medicare pays your kidney doctor a monthly amount. After you pay the $131 (in 2007) Part B yearly deductible, Medicare Part B pays 80% of the monthly amount. You pay the remaining 20% coinsurance.

In some cases, your doctor may be paid per day if you get services for less than one month.

Example
Let's say the monthly amount that Medicare pays your doctor for each dialysis patient is $125. After you pay the $131 (in 2007) Part B yearly deductible,

- Medicare pays 80% of the $125 (or $100), and
- you pay the remaining 20% coinsurance (or $25).

Inpatient Doctors' Services

In the Original Medicare Plan, your kidney doctor bills separately for Medicare-covered ESRD services you get as an inpatient. In this case, your kidney doctor's monthly payment will be based on the number of days you stay in the hospital.

What YOU pay for Dialysis Services (continued)

Doctors' Services (continued)

Self-Dialysis Training

Words in red are defined on pages 51–52.

Self-dialysis training is covered by Medicare Part B on an outpatient basis. Self-dialysis training costs more than dialysis treatments. In the Original Medicare Plan, after you pay the $131 (in 2007) Part B yearly deductible, Medicare Part B will pay 80% of the training costs. You must pay the remaining 20% coinsurance.

Example
Let's say the cost per training session is $500. After you pay the $131 (in 2007) Part B yearly deductible,

- Medicare Part B pays 80% of the $500 (or $400 per session), and
- you must pay the remaining 20% coinsurance (or $100 per session).

Home Dialysis

You have two payment options for home dialysis: Method 1, Dealing directly with your dialysis facility, or Method 2, Dealing directly with your supplier.

The chart on the next page has specific information on what you pay for home dialysis equipment, supplies, and support services in the Original Medicare Plan using the Method 1 and Method 2 payment choices.

Kidney Dialysis

Payment Chart for Home Dialysis Equipment, Supplies, and Support Services

Method 1 Dealing Directly with Your Dialysis Facility	Method 2 Dealing Directly with Your Supplier
Under this option, you must get all services, equipment, and supplies needed for home dialysis from your dialysis facility.	Under this option, you must get your dialysis equipment and supplies from one supplier. Your supplier must accept assignment. Your supplier must also have a written agreement with a dialysis facility to make sure you will get all necessary home dialysis support services.
For Home Dialysis **Equipment**, **Supplies,** and **Support** Services— Medicare pays 80% of the facility's composite rate. You pay the remaining 20% coinsurance, after you pay the $131 (in 2007) Part B yearly deductible (see note below).	For Home Dialysis **Equipment**— If you buy or rent home dialysis equipment, Medicare Part B will cover it. You must pay the $131 Part B yearly deductible in 2007 (see note below). If you rent the equipment, Medicare Part B usually makes monthly payments to the supplier. If you buy the equipment, Medicare will pay 80% of the monthly payment purchase price until the Medicare-approved purchase price is reached. You pay the remaining 20% coinsurance. The monthly Part B payment includes any interest or carrying charges. If you rent the equipment, Medicare Part B pays 80% of the approved monthly rental charge You pay the remaining 20% coinsurance.
	For Home Dialysis **Supplies** and **Support** Services— A private company that pays Medicare bills pays the facility 80% of the approved charges for all covered support services. Medicare pays the supplier 80% of the approved charges for all covered supplies. You pay the remaining 20% coinsurance, for both support services and supplies after you pay the $131 (in 2007) Part B yearly deductible (see note below.)

Note: In 2007, you pay only one Part B deductible of $131. This amount can change each year.

What YOU pay for Dialysis Services (continued)

Deciding Which Payment Option to Choose For Home Dialysis

Look at the Method 1 and Method 2 payment chart on page 23.

Words in red are defined on pages 51–52.

It can help you decide which payment option is best for you if you are in the Original Medicare Plan. If you still have trouble deciding, ask a social worker at your dialysis facility to help you.

After you have finished self-dialysis training and are ready to make a choice, you must

1. fill out a Beneficiary Selection Form CMS-382.
2. sign the form.
3. return the form to your dialysis facility.

You can get a copy of Form CMS-382 from your dialysis facility. Once you make your choice and turn in the form, you must stay with that payment option until December 31 of that year. For example, if you decide to go with the payment Method 2 in August 2007, you must stay with that option until December 31, 2007.

You can change from one option to the other by filling out a new Form CMS-382 at any time, but the change will not start until the following January 1. For example, if you fill out your Form CMS-382 to change to Method 1 and return it to your dialysis facility in October 2007, this change will not start until January 1, 2008.

What YOU pay for Dialysis Services (continued)

How Long Will Medicare Pay For Home Dialysis Equipment?

Medicare Part B will pay for home dialysis equipment as long as you need dialysis at home. If you no longer need home dialysis, Part B will stop paying. For example, if you had a kidney transplant and no longer need home dialysis, then Part B would stop paying for your equipment.

If you buy your dialysis equipment, Part B payments will stop once the Medicare-approved purchase price is reached. For example, if Medicare agrees to pay $350 for your dialysis equipment, Part B payments will stop once Medicare pays $350.

Dialysis When You Travel

You can still travel in the United States even if you need dialysis. Your facility can help you plan your treatment along the route of your trip before you travel. Your dialysis facility will help you by checking to see if the facilities on your route

- are approved by Medicare to give dialysis.
- have the space and time to give care when you need it.
- have enough information about you to give you the right treatment.

There are over 3,500 facilities around the country. Your facility or the ESRD Network (see page 46) can help you get the names and addresses of those facilities.

In general, Medicare will pay only for hospital or medical care that you get in the United States.

Caution: If you get your dialysis services from a Method 2 supplier (see page 23) or a Medicare Advantage Plan, your supplier or Medicare Advantage Plan may be able to help you arrange to get the dialysis you need while you travel. Contact your supplier or health plan for more information.

Transportation to Dialysis Facilities

Does Medicare Pay for Transportation to Dialysis Facilities?

In most cases, no. Medicare covers roundtrip ambulance services from home to the nearest dialysis facility **only** if other forms of transportation would be harmful to your health.

The ambulance supplier must get a written order from your doctor before you get the ambulance service. The doctor's written order must be dated no earlier than 60 days before you get the ambulance service.

For more information about ambulance coverage, call 1-800-MEDICARE (1-800-633-4227). Or, visit www.medicare.gov on the web. Under "Search Tools," select "Find a Medicare Publication" to read or print the booklet "Medicare Coverage of Ambulance Services" (CMS Pub. No. 11021).

Words in red are defined on pages 51–52.

Visit www.medicare.gov on the web to get information about Medicare-certified dialysis facilities in your area. Select "Compare Dialysis Facilities in Your Area."

3

Kidney Transplants

What is a Kidney Transplant?

A kidney transplant is a type of surgery that is done to put a healthy kidney from another person into your body. This new kidney does the work that your own kidneys can't do. You may get a kidney from someone who has recently died, or from someone who is still living, like a family member. The blood and tissue of the person who gives you the kidney must be tested. This is done to see how well they match yours so that your body won't reject the new kidney.

Where to Get a Kidney Transplant

To be covered by Medicare, your kidney transplant must be done in a hospital that is approved by Medicare to do kidney transplants.

> If you have a problem with the care that you're getting for your transplant, you have the right to file a grievance (complaint) to resolve your problem. See page 40, "Filing a Grievance (Complaint)," for more information.

Kidney Transplants

Kidney Transplant Services Covered by Medicare

Medicare covers these transplant services and pays part of their costs:

Service or Supply	Medicare Part A	Medicare Part B
Inpatient services in an approved hospital	✔	
Kidney Registry Fee	✔	
Laboratory and other tests needed to evaluate your medical condition*	✔	
Laboratory and other tests needed to evaluate the medical condition of potential kidney donors*	✔	
The costs of finding the proper kidney for your transplant surgery (if there is no kidney donor)	✔	
The full cost of care for your kidney donor (including care before surgery, the actual surgery, and care after surgery)	✔	
Any additional inpatient hospital care for your donor in case of problems due to the surgery	✔	
Doctors' services for kidney transplant surgery (including care before surgery, the actual surgery, and care after surgery)		✔
Doctor's services for your kidney donor during their hospital stay		✔
Immunosuppressive drugs (for a limited time after you leave the hospital following a transplant, see pages 29–30). See pages 35–38 for information about Medicare Prescription Drug Plans.		✔
Blood (whole or units of packed red blood cells, blood components, and the cost of processing and giving you blood, see pages 33–34)	✔	✔

Note: Buying or selling human organs is against the law. Therefore, Medicare doesn't pay for the kidneys used for transplant.

To find out what you pay for these services, see pages 31–32.

* These services are covered whether they are done by the Medicare-approved hospital where you will get your transplant, or by another hospital that participates in Medicare.

Kidney Transplants

Kidney Transplant Services Covered by Medicare (continued)

Transplant Drugs (called Immunosuppressive Drugs)

What are Immunosuppressive Drugs?

Immunosuppressive drugs are transplant drugs used to reduce the risk of your body rejecting your new kidney after your transplant. You will need to take these drugs for the rest of your life.

Important Note: In order for you to be covered by Medicare for immunosuppressive drugs, the conditions on page 12 must be met.

What if I Stop Taking My Transplant Drugs?

If you stop taking your transplant drugs, your body may reject your new kidney and the kidney could stop working. If that happens, you may have to start dialysis again. Talk to your doctor before you stop taking your transplant drugs.

How Long Will Medicare Pay for Transplant Drugs?

If you have Medicare only because of kidney failure, your Medicare coverage will end 36 months after the month of the transplant.

Medicare won't pay for any services or items, including immunosuppressive drugs, for patients who are not entitled to Medicare.

Medicare will continue to pay for your immunosuppressive drugs **with no** time limit if you

- already had Medicare because of age or disability before you got ESRD, or
- became eligible for Medicare because of age or disability after getting a transplant that was paid for by Medicare, or paid for by private insurance that paid primary to your Medicare Part A coverage, in a Medicare-certified facility.

If you have Medicare only because of kidney failure, your Medicare coverage will end when your 36-month period is up.

Kidney Transplant Services Covered by Medicare (continued)

What if I Can't Pay for the Transplant Drugs?

Transplant drugs can be very costly. If you have Medicare only because of kidney failure, your immunosuppressive drugs are only covered for 36 months after the month of your transplant. If you are worried about paying for them after your Medicare coverage ends, talk to your doctor, nurse, or social worker. There may be other ways to help you pay for these drugs. (See pages 41–44 to learn more about other health insurance.)

Special Information About Pancreas Transplants

If you have ESRD and need a pancreas transplant, Medicare covers a pancreas transplant if it's done

- at the same time you get a kidney transplant, or
- after a kidney transplant.

If you have Medicare only because of kidney failure, and you have the pancreas transplant after the kidney transplant, Medicare will only pay for your immunosuppressive drug therapy for 36 months after the month of the kidney transplant. If you already had Medicare because of age or disability before you got ESRD, or if you became eligible for Medicare because of age or disability after getting a transplant, Medicare will continue to pay for your immunosuppressive drugs with no time limit.

Kidney Transplants

What YOU Pay for Kidney Transplant Services

Words in red are defined on pages 51–52.

The amounts listed in this section are for transplant services covered in the Original Medicare Plan. If you are in a Medicare Advantage Plan, your costs may be different. Read your plan materials or call your plan to get information about your costs.

Do I Have to Pay for My Kidney Donor?

No. Medicare will pay the full cost of care for your kidney donor. You don't have to pay a deductible, coinsurance, or other costs for your donor's hospital stay.

Hospital Services

For 2007 in the Original Medicare Plan, you pay

- a total of $992 for a hospital stay of 1–60 days.
- $248 per day for days 61–90 of a hospital stay.
- $496 per day for days 91–150 of a hospital stay.
- all costs for each day beyond 150 days.

For Medicare-approved care in a skilled nursing facility, you pay

- nothing for the first 20 days.
- up to $124 per day for days 21–100 each benefit period.
- all costs for each day after day 100 in the benefit period.

To find out what you pay for other Medicare Part A and Part B services, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What YOU Pay for Kidney Transplant Services (continued)

Words in red are defined on pages 51–52.

Doctors' Services

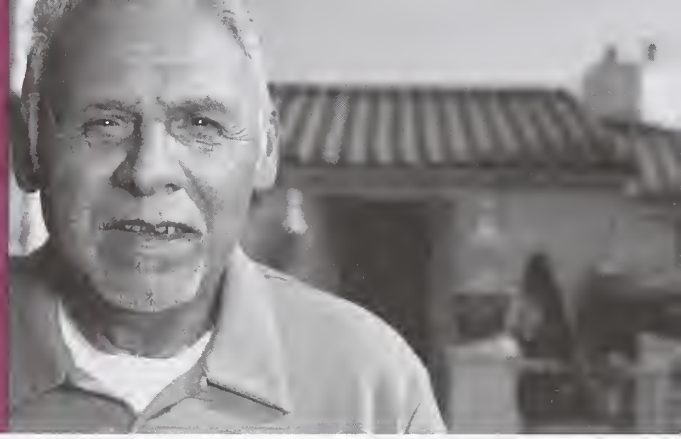
In the Original Medicare Plan, you must pay the $131 (in 2007) Part B yearly deductible. After you pay the deductible, Medicare Part B pays 80% of the Medicare-approved amount. You must pay the remaining 20% coinsurance.

Important: There is a limit on the amount your doctor can charge you, even if your doctor doesn't accept assignment. If your doctor doesn't accept assignment, you only have to pay the part of the bill that is over the Medicare-approved amount up to the limit that Medicare allows your doctor to charge.

Clinical Laboratory Services

You pay nothing for Medicare-approved laboratory tests.

4 How Medicare Pays for Blood



In most cases, Medicare Part A and Part B can help pay for

- whole blood units or packed red blood cells,
- blood components, and
- the cost of processing and giving you blood.

What YOU Pay for Blood

Under Medicare Part A, you pay for the first three units of whole blood or units of packed red cells that you get during a benefit period while you are staying in a hospital or skilled nursing facility. You can choose to either pay the hospital costs for the blood or packed red cells or to have the blood replaced (see "How to Have Blood Replaced," on the next page).

Note: If you have paid for or replaced some units of blood under Medicare Part B during the calendar year (January 1–December 31), you don't have to do so again under Medicare Part A.

Under Medicare Part B, you pay for the first three units of whole blood or units of packed red cells that you get in a calendar year. You can choose to either pay the hospital costs for the blood or packed red cells or you can have the blood replaced (see "How to Have Blood Replaced," on the next page).

In the Original Medicare Plan, Medicare Part B pays 80% of the Medicare-approved amount for extra pints of blood in a calendar year. You pay the remaining 20% coinsurance.

Note: If you have paid for or replaced blood under Medicare Part A during a calendar year (January 1–December 31), you don't have to do so again under Medicare Part B.

Words in red are defined on pages 51–52.

How Medicare Pays for Blood

How to Have Blood Replaced

You can replace the blood yourself by donating blood ahead of time, or getting another person or organization to replace the blood for you. The blood that is replaced doesn't have to match your blood type. If you decide to replace the blood yourself, check with your doctor first before donating blood.

Can I Be Charged for the Blood That I Have Replaced?

No. A hospital or skilled nursing facility can't charge you for any of the first three pints of blood you have already replaced or will have replaced. Also, if your hospital or skilled nursing facility receives donated blood or red blood cells, the blood or red blood cells are considered to be replaced.

> Medicare doesn't pay for blood for home self-dialysis unless it's part of a doctor's service or is needed to prime the dialysis equipment.

5 Medicare Prescription Drug Coverage

Medicare Part B covers immunosuppressive drugs and most of the drugs you get for dialysis (see pages 28–29). As a person with kidney disease, you may need prescription drugs for other health conditions you may have, like high blood pressure, high cholesterol, or diabetes. Medicare offers prescription drug coverage to help you with the costs of your drugs not covered by Medicare Part B.

> Medicare prescription drug coverage won't cover drugs you can get under Medicare Part B—such as immunosuppressive drug therapy under the conditions discussed on page 12. However, if you don't meet the conditions on page 12, you may be able to get coverage by joining a Medicare Prescription Drug Plan.

Medicare prescription drug coverage (Part D) is offered by private companies approved by Medicare. There are two types of Medicare plans that provide Medicare prescription drug coverage:

- Medicare Prescription Drug Plans that add coverage to the Original Medicare Plan.
- Prescription drug coverage as part of Medicare Advantage Plans (like an HMO and PPO). Most people with ESRD can get prescription drug coverage through a Medicare Advantage Plan if they already belong to the plan, or if they switch to a different plan offered by the same company.

What it Costs

Most Medicare drug plans charge a monthly premium that varies by plan. You pay this in addition to the Part B premium. Some plans have no premium at all. Your costs will vary depending on which drugs you use and which Medicare drug plan you choose. Also, if you have limited income and resources, you may get extra help paying for your prescription drug costs (see page 36). Look at your "Medicare & You" handbook to get detailed information about prescription drug coverage costs.

Words in red are defined on pages 51–52.

Extra Help for Those Who Need it Most

Words in red are defined on pages 51–52.

Medicare provides "extra help" to pay prescription drug costs for people who meet specific limits on income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan's monthly premium, yearly deductible, and prescription copayments or coinsurance.

To qualify for the extra help, your yearly income must be below $15,315 ($20,535 for a married couple living together) and your resources may be up to $11,710 ($23,410 for a married couple living together). These income amounts are for 2007.

If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, your income limits are higher. Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa have their own rules for providing extra help to their residents.

How Do I Apply for Extra Help?

Some people with Medicare automatically qualify for extra help and will get a letter from Medicare.

If you didn't automatically qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what to do next. Even if you don't qualify, you should consider joining a drug plan.

If you apply and qualify for extra help, you can either join a plan on your own or let Medicare enroll you in a plan. Medicare will send you a letter letting you know what plan it will enroll you in and when your coverage begins. You can switch plans one time from November 15–December 31 each year.

Medicare Prescription Drug Coverage

Compare Plans and Join

Medicare prescription drug coverage varies by plan. You should compare the Medicare drug plans in your area and choose coverage that meets your needs. You can get personalized help comparing Medicare prescription drug coverage by visiting www.medicare.gov on the web. Under "Search Tools," select "Compare Medicare Prescription Drug Plans." Or, call 1-800-MEDICARE (1-800-633-4227) to compare plans in your area. You can also look at your copy of the "Medicare & You" handbook. When comparing plans, you will need to look at the plans' drug coverage, costs, and participating pharmacies.

After you have compared and selected a plan, it's time to join. Contact the plan you are interested in to find out how to enroll.

After you enroll, you will get information from the plan telling you when your coverage begins. You will also get membership materials including a plan member card. You use this card when you go to the pharmacy to get your prescriptions filled. When you use the card, you will get discounts on your covered prescriptions.

When You Can Join

If you are new to Medicare, you can first join a Medicare drug plan

- three months before to three months after you are first eligible for Medicare (if you are eligible for Medicare based on ESRD).
- three months before to three months after your 65th birthday (if you are eligible for Medicare based on age).
- three months before to three months after your 25th month of cash disability benefits (if you are eligible for Medicare based on disability).

Your prescription drug coverage will start the same time your Medicare coverage begins (see page 9).

When You Can Join (continued)

If you don't join when you are first eligible, you can join from November 15–December 31 of each year. Your coverage will begin on January 1 of the following year. However, if you join during this time and there was a period of 63 continuous days or more during which you didn't have creditable prescription drug coverage, you may have to pay a late enrollment penalty. This amount changes every year. You will have to pay this penalty as long as you have Medicare prescription drug coverage.

For more information on Medicare prescription drug coverage, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also contact your local State Health Insurance Assistance Program (see pages 49–50).

6 Appeals and Grievances

Your Medicare Rights

Words in red are defined on pages 51–52.

If you have Medicare, you have certain guaranteed rights to help protect you. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. **Whether you are in the Original Medicare Plan or a Medicare Advantage Plan, you have the right to appeal.**

Some of the reasons you may appeal are when

- you don't agree with the amount that is paid.
- a service or item isn't covered and you think it should be covered.
- a service or item is denied and you think it should be paid.

Appeal Rights in the Original Medicare Plan

If you are in the Original Medicare Plan, you can file an appeal for any of the reasons listed above. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why Medicare didn't pay your bill and how you can appeal.

Appeal Rights in a Medicare Advantage Plan

If you are in a Medicare Advantage Plan, you can file an appeal for any of the reasons listed above. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. You may also call 1-800-MEDICARE (1-800-633-4227) to ask for more information about your rights during an appeal. TTY users should call 1-877-486-2048.

Appeals and Grievances

Filing a Grievance (Complaint)

What to Do if You Have Problems With the Services You Get

Words in red are defined on pages 51–52.

- Talk with your doctor, nurse, or facility administrator first to see if they can help you solve your problem. Most problems can be handled at your facility.
- If talking to your health care team doesn't solve the problem, you can file a grievance (a written complaint) with your facility.

Every facility has a grievance policy for accepting and trying to work out your problems or concerns. If you don't know your facility's grievance policy, you can ask for a copy of it.

If you filed a grievance with your facility and you still feel that your problem has not been solved, you have the right to file a grievance with the ESRD Network (see pages 49–50) in your area. Call the ESRD Network to find out what you have to do in order to file a grievance. You can also call your State Survey Agency to complain about your care. Your calls and who you are will be kept private. Call 1-800-MEDICARE (1-800-633-4227) and ask for the number to your State Survey Agency. Or, visit www.medicare.gov on the web. Under "Search Tools," select "Find Helpful Phone Numbers and Websites."

7 Other Kinds of Health Insurance

There are several other kinds of health insurance coverage that may help pay for the services you need for the treatment of kidney failure.

They include the following:

1. Employee or Retiree Coverage From an Employer or Union
2. Medigap (Medicare Supplement Insurance) Policies
3. Medicaid
4. Veterans' Benefits

1. Employee or Retiree Coverage From an Employer or Union

If you have group health plan coverage based on your or your spouse's past or current employment, or your parents' current employment, call your benefits administrator to find out what coverage they might provide for your kidney failure. If you might be eligible for coverage under the group health plan, but have not signed up for it, call the benefits administrator to find out if you can still enroll.

Generally, employer or union group health plans have better rates than you can get if you buy a Medigap policy yourself, directly from an insurance company. Also, employers may pay part of the cost of the coverage.

In some cases, employer group health plans will have to pay before Medicare pays (see pages 11–13).

2. Medigap (Medicare Supplement Insurance) Policies

Words in red are defined on pages 51–52.

A Medigap policy is health insurance sold by private insurance companies to help fill the "gaps" in Original Medicare Plan coverage like deductibles and coinsurance. Medigap policies help pay some of the health care costs that the Original Medicare Plan doesn't cover. Medigap insurance must follow Federal and state laws that protect you. All Medigap policies are clearly marked "Medicare Supplement Insurance."

However, not all insurance companies will sell Medigap policies to people with Medicare under age 65. If a company does sell Medigap policies voluntarily, or because state law requires it to, these Medigap policies will probably cost you more than if you were 65 or older. Medigap rules vary from state to state. Call your State Health Insurance Assistance Program (see pages 49–50) for information about buying a Medigap policy if you are disabled or have ESRD.

For more detailed information about Medigap policies, visit www.medicare.gov on the web.

- ✔ Under "Search Tools," select "Find a Medicare Publication" to read or print a copy of the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" (CMS Pub. No. 02110).
- ✔ Select "Compare Health Plans and Medigap Policies in Your Area" to get information on Medigap policies in your state. When you use this website, you will get a personalized summary page with general information to help you compare plans in your area. You can get detailed information about all the plans available in your area, or just the ones you are most interested in. This website has the following information:
  - Which Medigap policies are sold in your state
  - Comparing Medigap policies
  - What each policy covers
  - Your out-of-pocket costs

If you don't have a computer, your local library or senior center may be able to help you look at this information.

3. Medicaid

This is a joint Federal and state program that helps pay medical costs for some people with limited income and resources. Medicaid programs vary from state to state. Most health care costs are covered if you qualify for both Medicare and Medicaid.

States also have Medicare Savings programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who have Medicare and a limited income. To qualify for these programs, you must

- have Medicare Part A (hospital). If you're not sure if you have Part A, look at your red, white, and blue Medicare card or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
- have a monthly income of less than $1,169 for an individual or $1,561 for a couple in 2007. These income limits are slightly higher in Hawaii and Alaska. Income limits can change each year.
- have savings of $4,000 or less for an individual, or $6,000 or less for a couple. Savings include money in a checking or savings account, stocks, and bonds.

To get more information on these programs, call 1-800-MEDICARE (1-800-633-4227), and ask for information on "savings for people with Medicare." TTY users should call 1-877-486-2048.

Other Kinds of Health Insurance

4. Veterans' Benefits

If you are a veteran, the U.S. Department of Veterans Affairs can help pay for ESRD treatment. For more information, call the U.S. Department of Veterans Affairs at 1-800-827-1000. If you or your spouse is retired from the military, call the Department of Defense at 1-800-538-9552 for more information.

Other Ways to Get Help

In most states there are agencies that help with some of the health care costs that Medicare doesn't pay. Some states also have Kidney Commissions that help people pay the costs that Medicare doesn't pay. Call your State Health Insurance Assistance Program if you have questions about health insurance (see pages 49–50).

8 Where to Get More Information

Talk with your health care team to learn more about kidney dialysis, transplants, and your situation. Your doctors, nurses, social workers, dieticians, and dialysis technicians make up your health care team.

Kidney Organizations

There are special organizations that can give you more information about kidney dialysis and kidney transplants. Some of these organizations have members who are on dialysis or have had kidney transplants and who can give you support.

American Association of Kidney Patients
3505 E. Frontage Rd.
Ste. 315
Tampa, Florida 33607
1-800-749-2257
www.aakp.org

American Kidney Fund
6110 Executive Blvd. Suite 1010
Rockville, MD 20852
1-800-638-8299
www.akfinc.org

National Kidney Foundation, Inc.
30 East 33rd Street
New York, NY 10016
1-800-622-9010
www.kidney.org

National Kidney and Urologic Diseases Information Clearinghouse
3 Information Way
Bethesda, MD 20892-3580
1-800-891-5390
www.kidney.niddk.nih.gov

Where to Get More Information

End-Stage Renal Disease (ESRD) Networks

You can call your local ESRD Network Organization (see pages 49–50) to get information about

- dialysis or kidney transplants.
- how to get help from other kidney-related agencies.
- problems with your facility that are not solved after talking to the staff at the facility.
- location of dialysis facilities and transplant centers.

Your ESRD Network makes sure that you are getting the best possible care, and keeps your facility aware of important issues about kidney dialysis and transplants.

State Health Insurance Assistance Program (SHIP)

Call your State Health Insurance Assistance Program (see pages 49–50) if you have questions about

- Medigap policies.
- Medicare health plan choices.
- help with filing an appeal.
- other general health insurance questions.

State Survey Agency

The State Survey Agency inspects dialysis facilities and makes sure that Medicare standards are met. Your State Survey Agency can also help you if you have a complaint about your care. Call 1-800-MEDICARE (1-800-633-4227) and ask for the number of your State Survey Agency. Or, visit www.medicare.gov on the web. Under "Search Tools," select "Find Helpful Phone Numbers and Websites." **Your calls and name will be kept private.**

Where to Get More Information

Other Medicare Booklets for Kidney Patients

Medicare has other booklets for kidney patients:

To read or print a copy of these booklets, visit www.medicare.gov on the web. Under "Search Tools," select "Find a Medicare Publication." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if these booklets are available in print. TTY users should call 1-877-486-2048.

1. "You Can Live: Your Guide for Living with Kidney Failure" (CMS Pub. No. 02119)

This guide gives you important information about treating kidney failure, making treatments better, and living a healthier life. It also gives tips on working with your health care team and who to ask for assistance if you have concerns or need more information about kidney disease.

2. "Preparing for Emergencies: A Guide for People on Dialysis" (CMS Pub. No. 10150)

This guide gives you important facts about what to do in case of an emergency that leaves you without power or water. It guides you through the information you should have ready, provides lists of supplies to have on hand to prepare for emergencies, and gives helpful ideas on how to manage until conditions return to normal.

3. "Dialysis Facility Compare" (CMS Pub. No. 10208)

This brochure gives you information about the Dialysis Facility Compare tool at www.medicare.gov on the web.

Where to Get More Information

Important Phone Numbers

ESRD Networks and State Health Insurance Assistance Program phone numbers are on pages 49–50. At the time of printing, these phone numbers were correct. Phone numbers sometimes change. To get the most updated phone numbers call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, visit www.medicare.gov on the web. Under "Search Tools," select "Find Helpful Phone Numbers and Websites."

Where to Get More Information

State	State Health Insurance Assistance Program	ESRD Networks
Alabama	1-800-243-5463	1-877-936-9260
Alaska	1-800-478-6065	1-800-262-1514
American Samoa	Not available	1-800-232-3773
Arizona	1-800-432-4040	1-800-783-8818
Arkansas	1-800-224-6330	1-800-472-8664
California	1-800-434-0222	1-800-637-4767 1-800-232-3773
Colorado	1-888-696-7213	1-800-783-8818
Connecticut	1-800-994-9422	1-866-286-3773
Delaware	1-800-336-9500	1-800-548-9205
Florida	1-800-963-5337	1-800-826-3773
Georgia	1-800-669-8387	1-800-524-7139
Guam	1-671-735-7382	1-800-232-3773
Hawaii	1-888-875-9229	1-800-232-3773
Idaho	1-800-247-4422	1-800-262-1514
Illinois	1-800-548-9034	1-800-456-6919
Indiana	1-800-452-4800	1-800-456-6919
Iowa	1-800-351-4664	1-800-444-9965
Kansas	1-800-860-5260	1-800-444-9965
Kentucky	1-877-293-7447	1-800-456-6919
Louisiana	1-800-259-5301	1-800-472-8664
Maine	1-877-353-3771	1-866-286-3773
Maryland	1-800-243-3425	1-866-651-6272
Massachusetts	1-800-243-4636	1-866-286-3773
Michigan	1-800-803-7174	1-800-973-3773
Minnesota	1-800-333-2433	1-800-973-3773
Mississippi	1-800-948-3090	1-800-562-2957
Missouri	1-800-390-3330	1-800-444-9965

Where to Get More Information

State	State Health Insurance Assistance Program	ESRD Networks
Montana	1-800-551-3191	1-800-262-1514
Nebraska	1-800-234-7119	1-800-444-9965
Nevada	1-800-307-4444	1-800-783-8818
New Hampshire	1-800-852-3388	1-866-286-3773
New Jersey	1-800-792-8820	1-888-877-8400
New Mexico	1-800-432-2080	1-800-783-8818
New York	1-800-701-0501	1-800-238-3773
North Carolina	1-800-443-9354	1-800-524-7139
North Dakota	1-888-575-6611	1-800-973-3773
Ohio	1-800-686-1578	1-800-456-6919
Oklahoma	1-800-763-2828	1-800-472-8664
Oregon	1-800-722-4134	1-800-262-1514
Pennsylvania	1-800-783-7067	1-800-548-9205
Puerto Rico	1-877-725-4300	1-888-877-8400
Rhode Island	1-401-462-4444	1-866-286-3773
South Carolina	1-800-868-9095	1-800-524-7139
South Dakota	1-800-536-8197	1-800-973-3773
Tennessee	1-877-801-0044	1-877-936-9260
Texas	1-800-252-9240	1-877-886-4435
Utah	1-800-541-7735	1-800-783-8818
Vermont	1-800-642-5119	1-866-286-3773
Virgin Islands	1-340-772-7368	1-888-877-8400
Virginia	1-800-552-3402	1-866-651-6272
Washington	1-800-562-6900	1-800-262-1514
Washington D.C.	1-202-739-0668	1-866-651-6272
West Virginia	1-877-987-4463	1-866-651-6272
Wisconsin	1-800-242-1060	1-800-973-3773
Wyoming	1-800-856-4398	1-800-783-8818

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Words to Know

Appeal—A special kind of complaint you make if you disagree with certain kinds of decisions made by Medicare, or your health or prescription drug plan. You can appeal if you request a health care service, supply, or prescription that you think you should be able to get, or you request payment for health care you already got, and Medicare or a plan denies the request.

Assignment—An agreement between a person with Medicare, a doctor or supplier, and Medicare. The person with Medicare agrees to let the doctor or supplier request direct payment from Medicare for covered Part B services, equipment, and supplies. Doctors or suppliers who agree to (or must by law) accept assignment from Medicare can't try to collect more than the Medicare deductible and coinsurance amounts from the person with Medicare, the person's other insurance (if any), or from anyone else.

Benefit Period—The way that the Original Medicare Plan measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't had any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins.

You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods, although inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

Coinsurance—The amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the deductible for Part A and/or Part B. In a Medicare Prescription Drug Plan, the coinsurance will vary depending on how much you have spent.

Coordination Period—An amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the Part A and/or Part B deductible. In a Medicare Prescription Drug Plan, the coinsurance will vary depending on how much you have spent.

Words to Know

Deductible—The amount you must pay for health care or prescriptions before the Original Medicare Plan, your prescription drug plan, or other insurance begins to pay. For example, in the Original Medicare Plan you pay a new deductible for each benefit period for Part A and each year for Part B. These amounts can change every year.

End-Stage Renal Disease (ESRD)—Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Grievance—A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have a problem with the cleanliness of the health care facility, problems calling the plan, staff behavior or care provided. A grievance is not the same as an appeal, which is the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).

Medically Necessary—Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare Advantage Plan—A type of Medicare plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Everyone who has Medicare Parts A and B is eligible, except people who have End-Stage Renal Disease unless certain exceptions apply.

Medicare-Approved Amount—In the Original Medicare Plan, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Original Medicare Plan—The Original Medicare Plan has two parts: Part A (hospital) and Part B (medical). It is a fee-for-service health plan. You must pay the deductible. Then Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Secondary Payer—The insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.

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Important Phone Numbers

	Phone Number
Doctor	
_____	___-___-____
Social Worker	
_____	___-___-____
Health Insurance Company	
_____	___-___-____
ESRD Network	
_____	___-___-____
State Survey Agency	
_____	___-___-____
_____	___-___-____
_____	___-___-____
_____	___-___-____

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